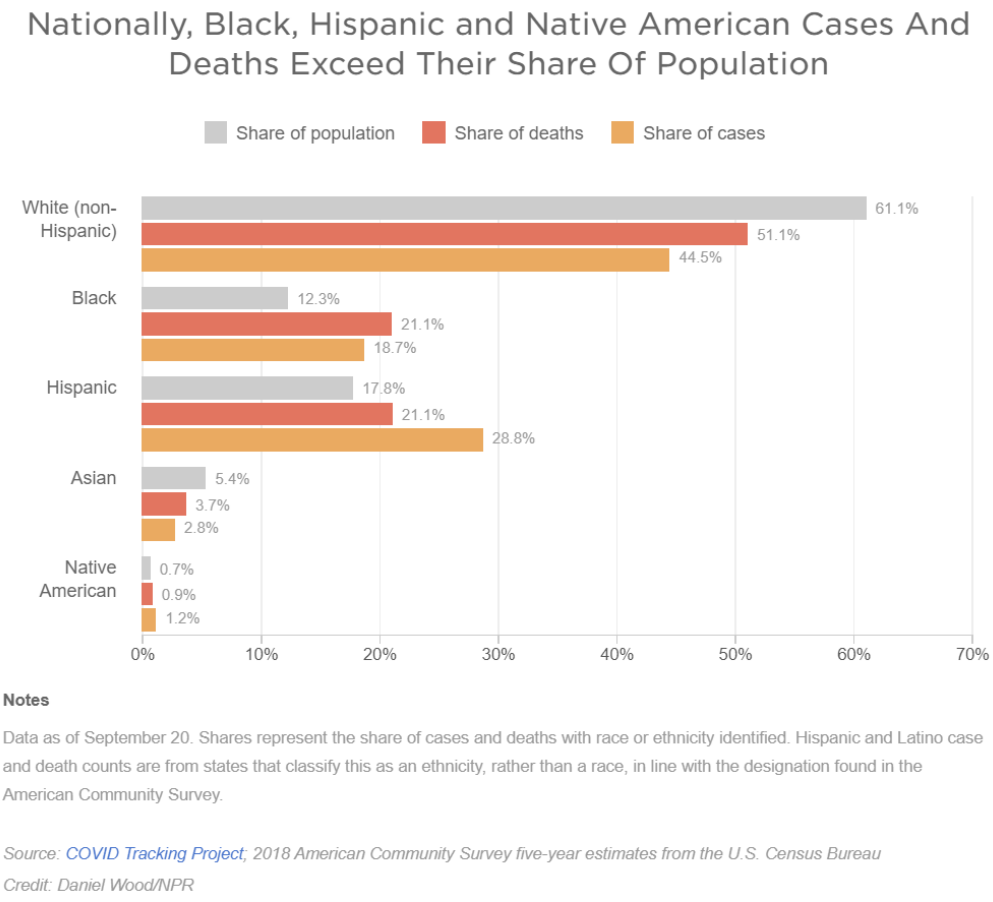
As Pandemic Deaths Add Up, Racial Disparities Persist — And In Some Cases Worsen
NPR – view article and additional data & charts here
September 2020

Data gathered early in the pandemic showed that communities of color are disproportionately affected by COVID-19 across the United States. But incomplete data left a muddy picture of these disparities.

Today, as the U.S. has surpassed 200,000 COVID-19 deaths, and reached nearly 7 million confirmed cases, racial data is more complete, and the trend is crystal clear: People of color get sick and die of COVID-19 at rates higher than whites and higher than their share of the population.

The trend has persisted — and in some cases worsened — since NPR analyzed this data in May. As the country struggles to bring the pandemic under control, Blacks, Latinos and Native Americans bear an unequal burden.



An NPR analysis of the latest data available from the COVID Tracking Project shows how this plays out state by state. (Jump to charts below to look up your state). Here are the key findings of the national picture:

- African Americans continue to get infected and die from COVID-19 at rates more than 1.5 times their share of the population.

- In Missouri, Kansas, Wisconsin and Michigan, African Americans are dying at a rate more than 2.5 times their share of the population.
- Increasingly, Hispanics and Latinos die from COVID-19 at rates higher than their share of state populations. In May, this was true in only seven states, but now it is true in 19 states and the District of Columbia.
- Hispanics and Latinos have a disproportionate rate of infection in 45 states and the District of Columbia.
- The Native American and Alaskan Native share of death and sickness is disproportionate to their population in 21 states out of the 36 states with sufficient data. That rate is five or more times greater than population share in Utah, Montana, New Mexico and Wyoming.
- White, non-Hispanic deaths from COVID-19 are lower than their share of the population in 36 states and the District of Columbia.

As the months have passed, the availability of statewide race and ethnicity data has increased dramatically. When NPR first reported on this issue in May, only 51% of cases and 88% of deaths had an identified race. Since then, 65% of new cases have an identified race, and states have been working to identify the race of deaths previously recorded without a race.

Researchers who have been tracking racial disparities in COVID-19 outcomes since early in the pandemic say these trends are now impossible to ignore.

Samantha Artiga, director of the Disparities Policy Project at Kaiser Family Foundation, recently published a distillation of a wide range of research on these racial disparities.

"When you look at that continually growing body of research, the findings very consistently show that people of color are really bearing the heaviest burden of COVID-19 at every stage, from risk of exposure, to access to testing, to severity of the illness and eventually death," she says.

And these trends are confirmed wherever COVID and race data are collected.

Increasingly, the CDC has provided a variety of race and ethnicity data, something it was slow to do initially. On August 18, the CDC released data showing that Blacks, Latinos, and American Indians are experiencing hospitalizations at rates 4.5 to 5.5 times higher than non-Hispanic whites.

The COVID Racial Data Tracker did an analysis comparing white death rates to other groups. Hispanics and Native Americans are both dying about 1.5 times the rate of white people. And African Americans are dying at 2.4 times the white rate.

NPR's analysis shows that nationally, this death rate is still the highest of any group, despite modest improvements since May. Blacks continue to be over-represented in deaths in 33 states and territories. In May, death rates in 9 states were more than double their population share. As of late September, they are double in only four states.

COVID-19 related deaths among Hispanics and Latinos are cause for increasing concern. In May, the national death rate for Latinos was below their proportion of the population, but it has steadily crept up. There are now 20 states where the number of Hispanic deaths is greater than their share of the population, up from just seven in May.

"I think this really reflects the shifting of hotspots into Southern and Western regions of the country where Hispanic people make up a greater share of the population," says Artiga.

Meanwhile, these communities test positive for COVID-19 at disproportionate rates in almost every state.

For American Indians and Alaska Natives, the picture has become clearer as data becomes available and sample sizes grow. At least 19 states have disproportionately high cases for AIAN individuals and 15 states have disproportionately high death rates. In Arizona, over 500 Native Americans have died from COVID-19, 12% of the state's overall tally. Only 4.5% of the population of Arizona is Native American.

Behind all these disparities lies an even deeper, entrenched problem of health inequity in our society, explains Greg Millet, director of public policy at amfAR.

"It's not by dint of circumstance or luck that predominantly white counties — by and large — have not had as many diagnoses as compared to more diverse counties," he says. "There's a systemic issue that's underlying all of this."

As the pandemic stretches on — and these trends continue — the people meticulously collecting this information are fighting to keep perspective.

"At the end of the day, these numbers are huge, but each number is a human life lost or affected by this," says Rachel Lee, project manager at the COVID Racial Data Tracker. "These are actually people, family members and friends being killed."

"I pray [whenever] our data shifts — 'help me to see the people behind these numbers' — because otherwise, they're just going to be numbers."

Methodology

Coronavirus case and death data by race and ethnicity are based on publicly available data collected by the The COVID Racial Data Tracker. Race and ethnicity population data comes from the 2018 American Community Survey from the Census bureau. Certain territories are excluded from our analysis due to lack of recent demographic data. Due to the inconsistent race and ethnicity reporting from states, it is possible for the white category to include Hispanic/Latino individuals that are counted both as a race and a Hispanic/Latino ethnicity. These inconsistencies could cause a slight overestimate in white case and death rates and a slight underestimate in Hispanic/Latino case and death rates. Where possible, we use the ACS count for non-Hispanic whites, rather than all whites.

In a Pandemic, All Some People See Is Your Color
The Atlantic
June 2020

The last night i went out in the city was in late February. I met my friend Grant (whose name has been changed) at the Standard, on Bowery, and we walked over to Bohemian, on Great Jones, to celebrate the 50th birthday of a Broadway producer. After dinner we went down the street to Acme, where a tech entrepreneur was having a dance party to celebrate his 40th. Grant sipped his tequila and began to grow irate because there were so few people of color around. It felt like the 1950s. We were talking to a beautiful Ghanaian woman whom I'd met once before, and when she mentioned a house party in Harlem that a mutual acquaintance was throwing, Grant and I invited ourselves. But as we glided up the FDR we heard the party was a bust. We dropped her off at home and headed to Koreatown, as though we knew it would be one of the last nights we could go out. We ended up in a bar on 34th Street, giving each other the kind of questionable advice that pours out after midnight, when Grant started to thumb at one of his phones.

"It's Fan," he said. (Her name has also been changed.) "She's been under strict quarantine for a month now, and is getting bored." I shot him a skeptical look as they began to have a text war. They had one of those relationships that reminds you the root of passion is suffering. His parents were immigrants from Taiwan, and he believed he could only ever be happy with an Asian woman. I wasn't sure I believed him. She wasn't always as nice to him as she could be. He spoke of his own failings, explained that the friction between them was cultural, and insisted I'd never understand. When he visited China he felt seen, and free of the constant weight of race. I couldn't argue with that, so I shrugged the way you do when a friend in whom you have faith is navigating something complicated. He told me that weeks in isolation give you time to reflect. "With all that's going on, though, who knows when I'll see her." Neither of us knew we would also go into isolation soon. But before the skylarking ended he told me he'd heard that the official numbers in China were underreported: "They say there were five crematoriums burning around the clock."

In the United States, the virus was still mostly centered on the West Coast then, but when I spoke with Grant a few days later he told me three cabs had passed him as he was trying to get to a meeting. "I've seen it happen to my college roommate. I've just never experienced it directly," he said. "Even an Asian guy looked into my face and kept going." I wanted to say maybe the cabbie knew about his girlfriend in Sichuan province, but thought better of it. He was still in pain from the affront. Both Grant and his former roommate, who is African American, are Ivy League lawyers, held in high regard by corporate chiefs and presidents. They thought being brilliant, ethical, and successful would protect them. But no matter who you were, or what you had achieved, it could all collapse at any time into race.

Grant's parents came to America after World War II, part of the second significant wave of Chinese immigration, driven by the new spirit of global cooperation. The first wave had been more than a century earlier, during the California gold rush of the 1850s. But in 1882 Congress passed a law ending further immigration of laborers from China, and the Supreme Court upheld it in 1889. Yet just three years before that, the justices had ruled in *Yick Wo v. Hopkins* that the Chinese people already here, citizens or not, were entitled to equal protection under the Fourteenth Amendment. At the same time,

the Court was engaged in a series of rulings that stripped Fourteenth Amendment rights from the people for whom it had been enacted in the first place: formerly enslaved African Americans. In *Plessy v. Ferguson*, Justice John Marshall Harlan referenced the *Wo* decision in his famous dissent, in which he wrote:

> There is a race so different from our own that we do not permit those belonging to it to become citizens of the United States. Persons belonging to it are, with few exceptions, absolutely excluded from our country. I allude to the Chinese race. But by the statute in question, a Chinaman can ride in the same passenger coach with white citizens of the United States, while citizens of the black race [cannot].

The messages are more mixed than those in a fraught relationship—sometimes you're a vile threat; other times you are useful.

Between 1948, when President Harry Truman integrated the armed forces, and 1964, when President Lyndon B. Johnson signed the Civil Rights Act into law, the legal protections that had been ripped away from African Americans post-Reconstruction were slowly restored. That changed with the election of Richard Nixon in 1968: The re-embrace of racist policy began, and white grievance became a core tenet of the Republican Party, culminating in the 2016 election of Donald Trump. By the logic of the radical extremism our current president represents, a global pandemic that began in a province of China was called the "Chinese virus." Rhode Island sought to bar New Yorkers. Gun sales around the country skyrocketed. My friend was snubbed by taxi drivers, even though the vectors of disease were not Asian Americans but the conditions of global existence. With breathtaking swiftness, he lost his individual status, as well as the group status of model minority (always a muddy buffer between whiteness and the continuing oppression of African Americans). The sense of belonging and accomplishment had been doled out and revoked according to the perceptions and needs of whiteness—a bait and switch that Arab Americans know all too well. This was merely the beginning of the ways the pandemic continues to expose the racism beneath the facade of American diversity and exceptionalism.

In the days before the quarantine I did what everyone else was doing: I bought face masks, hand sanitizer, food. I called family and friends around the world. I heard from a friend in California whose brother works at the Centers for Disease Control and Prevention. She told me he'd said not to worry. Two days later he told her that was only the official line. A friend in Spain wrote, saying: "I'm afraid." Someone mailed me a thermometer. Buying one had become impossible. I took my temperature three times a day. I called my mother, who was alone on her birthday, only to be met with reproach after I chided her for going to the grocery store. She needed ingredients to make herself something special, couldn't I understand? I got into an argument with my oldest friend, the kind of friend you've been arguing politics with since before you could vote, when he said that we'd beat this soon—"Come on, Cal," he said, "we're Americans."

I'd never thought very deeply about universal health care or a universal basic income until I saw the people who had inveighed against it anxiously awaiting the stimulus package, and cheering when the government saved Wall Street. I saw what was possible when there was something people really wanted to accomplish. Billionaires and celebrities made ostentatious displays of their concern. But it was plain

to see that some problems are so large, only a government can solve them—in fact, is designed to solve them. Transportation, war, poverty, education, public health.

A friend of a friend was intubated. A classmate was assigned to an ER in a part of Brooklyn where people weren't practicing social distancing. Another was running the COVID-19 unit at a hospital uptown. A third, usually an ice-cold bastard, broke down in tears on the way home from work. We were told there would be no difference in the ways medical care was allocated. People in medical circles were using the word *apocalypse*. But what happens before you get to the hospital?

By early April, it was well established that black people across the country were dying from the disease at about twice the rate of white people. As New York City Mayor Bill de Blasio noted, there is "a striking overlap of where this virus is doing the most damage and where we've had historic health-care disparities." The situation is much the same in Latino and Native American communities. "We could get wiped out," the CEO of the National Congress of American Indians, Kevin Allis, said. The virus doesn't discriminate, but the world we occupy does. In addition to the damage wrought by environmental pollution—higher in communities of color—and discrepancies in quality of care, there is also the stress of racism on the black body, most obviously manifest in the greater frequency of conditions such as high blood pressure. Even in normal times, black people's life expectancy is more than three years lower than white people's.

I debated for weeks whether to leave the city—looking for places that had good hospitals *and* where I'd be socially comfortable—before finally deciding to stay. "You can't outrun a virus," I replied to an ex, who had reached out to me from another country, recalling how things were after 9/11. In those days, I would wake early and read Marcus Aurelius before taking long walks next to the river at sunrise, thinking about the first Dutch settlement, the English takeover, the British campaign to hold the city during the Revolutionary War, and the market at the foot of Wall Street where Africans and Native Americans were sold. The ways the country changes and the ways it never seems to. You know how the mind wanders at that hour. Staring down at the streets of Brooklyn now, I think less about the plague and the 1918 flu than smallpox-infected blankets knowingly given to Native Americans; the syphilis transmitted by Europeans into a population that had never encountered the disease before; the yellow-fever epidemics of the 18th and 19th centuries that spread, port to port, from the Caribbean, like a florescent trace mark of the economics of slavery; and the malaria-ridden swamps where Africans died by the boatload to produce cotton, rice, and sugar. Homegrown tragedies for a nation that is as frail as it has ever been, and has still less care for the world.

Why Black Aging Matters, Too
Kaiser Health News
September 2020

Old. Chronically ill. Black.

People who fit this description are more likely to die from COVID-19 than any other group in the country.

They are perishing quietly, out of sight, in homes and apartment buildings, senior housing complexes, nursing homes and hospitals, disproportionately poor, frail and ill, after enduring a lifetime of racism and its attendant adverse health effects.

Yet, older Black Americans have received little attention as protesters proclaim that Black Lives Matter and experts churn out studies about the coronavirus.

“People are talking about the race disparity in COVID deaths, they’re talking about the age disparity, but they’re not talking about how race and age disparities interact: They’re not talking about older Black adults,” said Robert Joseph Taylor, director of the Program for Research on Black Americans at the University of Michigan’s Institute for Social Research.

A KHN analysis of data from the Centers for Disease Control and Prevention underscores the extent of their vulnerability. It found that African Americans ages 65 to 74 died of COVID-19 five times as often as whites. In the 75-to-84 group, the death rate for Blacks was 3½ times greater. Among those 85 and older, Blacks died twice as often. In all three age groups, death rates for Hispanics were higher than for whites but lower than for Blacks.

(The gap between Blacks and whites narrows over time because advanced age, itself, becomes an increasingly important, shared risk. Altogether, 80% of COVID-19 deaths are among people 65 and older.)

The data comes from the week that ended Feb. 1 through Aug. 8. Although breakdowns by race and age were not consistently reported, it is the best information available.

Mistrustful of Outsiders
Social and economic disadvantage, reinforced by racism, plays a significant part in unequal outcomes. Throughout their lives, Blacks have poorer access to health care and receive services of lower quality than does the general population. Starting in middle age, the toll becomes evident: more chronic medical conditions, which worsen over time, and earlier deaths.

Several conditions — diabetes, chronic kidney disease, obesity, heart failure and pulmonary hypertension, among others — put older Blacks at heightened risk of becoming seriously ill and dying from COVID-19.

Yet many vulnerable Black seniors are deeply distrustful of government and health care institutions, complicating efforts to mitigate the pandemic's impact.

The infamous Tuskegee syphilis study — in which African American participants in Alabama were not treated for their disease — remains a shocking, indelible example of racist medical experimentation. Just as important, the lifelong experience of racism in health care settings — symptoms discounted, needed treatments not given — leaves psychic scars.

In Seattle, Catholic Community Services sponsors the African American Elders Program, which serves nearly 400 frail homebound seniors each year.

"A lot of Black elders in this area migrated from the South a long time ago and were victims of a lot of racist practices growing up," said Margaret Boddie, 77, who directs the program. "With the pandemic, they're fearful of outsiders coming in and trying to tell them how to think and how to be. They think they're being targeted. There's a lot of paranoia."

"They won't open the door to people they don't know, even to talk," complicating efforts to send in social workers or nurses to provide assistance, Boddie said.

In Los Angeles, Karen Lincoln directs Advocates for African American Elders and is an associate professor of social work at the University of Southern California.

"Health literacy is a big issue in the older African American population because of how people were educated when they were young," she said. "My maternal grandmother, she had a third-grade education. My grandfather, he made it to the fifth grade. For many people, understanding the information that's put out, especially when it changes so often and people don't really understand why, is a challenge."

What this population needs, Lincoln suggested, is "help from people who they can relate to" — ideally, a cadre of African American community health workers.

With suspicion running high, older Blacks are keeping to themselves and avoiding health care providers.

"Testing? I know only of maybe two people who've been tested," said Mardell Reed, 80, who lives in Pasadena, California, and volunteers with Lincoln's program. "Taking a vaccine [for the coronavirus]? That is just not going to happen with most of the people I know. They don't trust it and I don't trust it."

Reed has high blood pressure, anemia, arthritis and thyroid and kidney disease, all fairly well controlled. She rarely goes outside because of COVID-19. "I'm just afraid of being around people," she admitted.

Other factors contribute to the heightened risk for older Blacks during the pandemic. They have fewer financial resources to draw upon and fewer community assets (such as grocery stores, pharmacies, transportation, community organizations that provide aging services) to rely on in times of adversity. And housing circumstances can contribute to the risk of infection.

In Chicago, Gilbert James, 78, lives in a 27-floor senior housing building, with 10 apartments on each floor. But only two of the building's three elevators are operational at any time. Despite a "two-person-per-elevator policy," people crowd onto the elevators, making it difficult to maintain social distance.

"The building doesn't keep us updated on how they're keeping things clean or whether people have gotten sick or died" of COVID-19, James said. Nationally, there are no efforts to track COVID-19 in low-income senior housing and little guidance about necessary infection control.

Large numbers of older Blacks also live in intergenerational households, where other adults, many of them essential workers, come and go for work, risking exposure to the coronavirus. As children return to school, they, too, are potential vectors of infection.

'Striving Yet Never Arriving'

In recent years, the American Psychological Association has called attention to the impact of racism-related stress in older African Americans — yet another source of vulnerability.

This toxic stress, revived each time racism becomes manifest, has deleterious consequences to physical and mental health. Even racist acts committed against others can be a significant stressor.

"This older generation went through the civil rights movement. Desegregation. Their kids went through busing. They grew up with a knee on their neck, as it were," said Keith Whitfield, provost at Wayne State University and an expert on aging in African Americans. "For them, it was an ongoing battle, striving yet never arriving. But there's also a lot of resilience that we shouldn't underestimate."

This year, for some elders, violence against Blacks and COVID-19's heavy toll on African American communities have been painful triggers. "The level of stress has definitely increased," Lincoln said.

During ordinary times, families and churches are essential supports, providing practical assistance and emotional nurturing. But during the pandemic, many older Blacks have been isolated.

In her capacity as a volunteer, Reed has been phoning Los Angeles seniors. "For some of them, I'm the first person they've talked to in two to three days. They talk about how they don't have anyone. I never knew there were so many African American elders who never married and don't have children," she said.

Meanwhile, social networks that keep elders feeling connected to other people are weakening.

"What is especially difficult for elders is the disruption of extended support networks, such as neighbors or the people they see at church," said Taylor, of the University of Michigan. "Those are the 'Hey, how are you doing? How are your kids? Anything you need?' interactions. That type of caring is very comforting and it's now missing."

In Brooklyn, New York, Barbara Apparicio, 77, has been having Bible discussions with a group of church friends on the phone each weekend. Apparicio is a breast cancer survivor who had a stroke in 2012 and walks with a cane. Her son and his family live in an upstairs apartment, but she does not see him much.

“The hardest part for me [during this pandemic] has been not being able to go out to do the things I like to do and see people I normally see,” she said.

In Atlanta, Celestine Bray Bottoms, 83, who lives on her own in an affordable senior housing community, is relying on her faith to pull her through what has been a very difficult time. Bottoms was hospitalized with chest pains this month — a problem that persists. She receives dialysis three times a week and has survived leukemia.

“I don’t like the way the world is going. Right now, it’s awful,” she said. “But every morning when I wake up, the first thing I do is thank the Lord for another day. I have a strong faith and I feel blessed because I’m still alive. And I’m doing everything I can not to get this virus because I want to be here a while longer.”

'Racial Inequality May Be As Deadly As COVID-19,' Analysis Finds
NPR
August 2020

Even during the COVID-19 pandemic, mortality rates and life expectancy are far better for white Americans than they are for Black people during normal, non-pandemic years, according to an analysis published this week in the *Proceedings of the National Academy of Sciences.*

The analysis, which looked at U.S. mortality statistics back to 1900, finds an additional 1 million white Americans would have to die this year in order for their life expectancy to fall to the best-ever levels recorded for Black Americans — back in 2014. That year, the average life expectancy for African Americans was 75.3 years — similar to the average life expectancy for white Americans back in 1989, says study author Elizabeth Wrigley-Field.

"It's as though Blacks have just missed out on the last three decades of [life expectancy] progress," says Wrigley-Field, a demographer and infectious disease historian at the Minnesota Population Center at the University of Minnesota.

The findings underscore the pandemic scale of the racial inequalities in mortality in the U.S., she says.

"We don't know what the ultimate scale of COVID-19 deaths is going to be," Wrigley-Field says. "But what we can say is that white deaths to COVID would have to increase from what they are right now by a factor of [more than] five to make white death rates this year look like the best that Black death rates have ever been."

She notes that 2014 was also the year when Black Americans had their lowest age-adjusted death rates on record — 1,061 deaths per 100,000. By comparison, for whites, the age-adjusted mortality rate was 899 per 100,000 in 2017 (the last year with available data). To match the *lowest* mortality rates on record for Black Americans, more than an additional 400,000 white Americans would have to die this year, her analysis found.

Thus far, COVID-19 has taken a disproportionate toll on Black people and other communities of color. Black Americans have experienced the highest death rates from the pandemic — about 88.4 deaths per 100,000, compared to 40.4 per 100,000 for white Americans, according to data compiled by the APM Research Lab.

As the Centers for Disease Control and Prevention noted in a report last week, there are multiple factors behind these pandemic disparities, including the facts that Black Americans and other people of color are disproportionately represented among essential workers who cannot perform their jobs while sheltering at home, and they're more likely to live in multigenerational households and crowded housing conditions that can increase the risk of exposure to the coronavirus.

But there are also longstanding systemic reasons behind these racial health disparities, notes Dr. Utibe Essien, a health equity researcher with the University of Pittsburgh — factors that include Black Americans' well-documented disparities in access to quality health care.

African Americans have higher rates of underlying medical conditions, including diabetes, heart disease and lung disease, that are linked to more severe cases of COVID-19. Black people in the U.S. also bear the burden of historic discrimination policies, Essien says, such as redlining policies in housing that limited African Americans' ability to accumulate wealth through property ownership. And wealth is a significant driver of health, Essien notes.

"I think it's important to ... appreciate that the pandemic didn't start something new, but that these disparities really, unfortunately, have been seen for decades, if not centuries," he says.

Indeed, Wrigley-Field says she was inspired to carry out the current analysis after conducting an earlier study on regional mortality rates from infectious disease during the early 20th century. "The thing that we found that stunned us was that white deaths in 1918 during the flu pandemic" — which killed more than a half-million Americans — "were less than what Black deaths had been in every prior year." A century later, she writes in her paper, "the basic fact endures that Black disadvantage is on the scale of the worst pandemics in modern U.S. history."

Wrigley-Field says she hopes her analysis will help reframe the discussion in the U.S. about the kinds of policy changes that society can realistically embrace to address health disparities stemming from systemic racism.

"To me, this really changes the question about how we think about, 'What are we willing to do to stop these deaths?' " she says. "Because we know what we're willing to do to stop deaths from COVID. We're basically willing to change every aspect of how we live, how we work, how we do our family lives, whether we travel, whether schools are in session. Absolutely everything is on the table. And all of that is controversial, but it's actually all pretty popular, too. "

"Meanwhile," she says, "we have this similar or probably larger scale of deaths happening every year, just to Blacks. But proposals that would try to address that in some way are often very controversial. Most people do not support, for example, reparations. Most people do not support defunding the police, although the opinions about that are changing pretty quickly. ... To me, these results, more than anything, just kind of reframe that question about what's realistic.

"So what are the things that we think are unimaginable that would address racism that we have to similarly say, we have no choice but to do this because the scale of death that's resulting is unacceptable?"

'Bear Our Pain': The Plea For More Black Mental Health Workers
NPR
June 2020

Two decades of life experience made a mental-health activist of Kai Koerber. When he was 16 and a student at a Parkland, Fla., high school, a gunman killed 17 people, including one his friends.

"I really did suffer a domestic terrorist attack, and that's not something that happens to you every day," Koerber says.

But as a young Black man growing up in the South, Koerber had already faced threats of racial and police violence routinely, and those experiences, too, shaped his relationship with the world. He's coped with that stress, he says, through a lifelong practice of meditation. And after the school massacre, Koerber also sought emotional support from a therapist with a deep empathy for his personal traumas.

"Finding a Black therapist really saved me some time, and there was more connection, in terms of the kinds of struggles that I might feel or the the kinds of ways I might think about certain scenarios," Koerber says.

Now a rising sophomore at the University of California, Berkeley, Koerber says having access to good mental health care is critical to both preventing and dealing with the after-effects of violence.

The need for mental health support is more evident than ever, especially among Black Americans, say people who study and experience the burden of racism. People of color were already dealing with heavy loads from a pandemic that continues to claim a greater proportion of Black, Latino and Native American lives and a greater share of jobs. Now there's the emotional reckoning following George Floyd's murder, which has stirred up a kind of collective trauma.

Meanwhile, the economic barriers to accessing mental health care have only increased.

Dr. Rhea Boyd says many members of the Black community feel emotionally raw and tapped out.

"We haven't been asked to publicly bear our pain as frequently as we are now, and we haven't had to witness other Black folks publicly baring their pain about it as frequently as we are now," says Boyd, a Bay Area pediatrician who studies the effects of police violence.

She says racism's toll threads through the psyche, manifesting in many ways, and shaping the youngest of brains. She worries most about Black girls, for whom suicide risk is increasing — not just among teenagers, but among preteens as well.

The need for mental health support, in other words, is great. But the history of meeting that need is not, says Dr. Ruth Shim, a psychiatrist at the University of California at Davis. The American system's abuse of African Americans spans generations — from forced experimentation to committing black civil rights activists to mental institutions.

Misdiagnosis prevalent

Misdiagnosis of Black people, Shim says, is still prevalent today — often by non-Black doctors who misread emotional cues like anger.

"We look at these things and call them 'disruptive behaviors,' we misdiagnose young people with things like 'conduct disorder' instead of the result of chronic trauma from racism," because many physicians haven't experienced it, Shim says.

For many Black patients, access to mental health treatment often comes in places of last resort: Jails, schools, emergency rooms. And studies show that African Americans tend to be given psychiatric diagnoses that are incorrect or especially severe or less treatable — such as schizophrenia instead of depression or bipolar disorder — and that can lead to inappropriate treatment. So, not surprisingly, Black patients who do get treatment tend to fare worse than white counterparts.

"I do think changing the workforce and changing the face of the workforce is probably the most critical thing that we can do now to start to address some of these issues," Shim says.

The scarcity of Black mental health professionals in the U.S. is now an acute problem, says Dr. Altha Stewart, a Memphis psychiatrist who became the first Black president of the American Psychiatric Association two years ago.

"I get calls from people right now asking, 'Can't you refer me to a Black psychiatrist?' And because there are so few of us, I'm limited in how many of those people's referrals I can make to their satisfaction," Stewart says. And that contributes to a lack of faith in health care among African Americans.

Stewart sees some signs of hope. In recent years, Black celebrities in sports and entertainment — like former NBA star Ron Artest, radio personality Charlamagne Tha God and actress Taraji P. Henson — started openly advocating for the importance of mental health screening and support. She says more Black faith leaders in churches and mosques are partnering with programs that help them connect congregants to treatment.

But at the moment, Stewart says, in the aftermath of the killing of George Floyd, the need is simply too great. "This was one bridge too many, one act too many, one heinous crime too many. It's something too much."

Education Inequality Starts Early
U.S. News and World Report
July 2017

Upper-middle-class American professionals spend a lot on their children's education and development. That fact – hardly news to anyone who has spent time with such parents – has gotten a lot of media attention lately, thanks to a new book by Brookings scholar Richard Reeves and a David Brooks column. Reeves' contention – that affluent professionals' investments in their kids serve to entrench a system of education-based privilege that makes it very hard for children from less advantaged backgrounds to advance up the socioeconomic ladder – has spurred heated debates on mainstream and social media.

These debates, however, often overlook just how early disparities in learning begin. Abundant research also shows that children's earliest learning experiences and outcomes also vary considerable based on their parents' incomes and education. The famous Hart and Risley study shows that children of professional parents are exposed to 30 million more words before age three than children from families in poverty, with significant consequences for language and cognitive development. Middle-class children are also more likely to be read to or exposed to educational and cultural opportunities, such as museums, zoos and libraries, than children in poverty.

As a result, by the time they enter kindergarten, children from the lowest socioeconomic backgrounds are already far behind their peers in the highest quartile of socioeconomic status on measures of early reading and math skills.

High-quality early childhood education programs can prevent or mitigate these disparities, but our current early care and education arrangements often exacerbate them instead. With 65 percent of mothers of young children working, most families need some type of child care for their children while mom is at work, but families' ability to access quality care varies based on income. Paying for care is a big challenge for low-income families: Census data indicates that poor families who pay for childcare spend 30 percent of their incomes on care, compared to 8 percent for families not in poverty. This means that lower-income families are less likely to send their children to formal child care at all, instead relying on a patchwork of informal arrangements. But such unstable arrangements don't support children's development or their parents' ability to maintain stable employment. For low-income families who do use formal child care, the high percentage of income going to care means less money for other investments in children's learning and development, such as books, museum trips or college savings.

The upshot is that children who most need quality early learning are the least likely to get it: Nearly 90 percent of 4-year-olds from families making over $100,000 attend preschool, compared to less than two-thirds of children in poverty. Programs like Head Start and state-funded preschool help many low-income children. But working-class and moderate-income children, whose parents make too much to qualify for publicly funded programs, but not enough to afford private preschool, are less likely than either rich or poor kids to attend preschool, amplifying the growing education disparities between children of professional and working class parents.

Are these early learning disparities solely a reflection of professional parents' type-A approach to childrearing? Sure, some upper-middle-class parents do some ridiculous things in the name of supporting their preschoolers' development. The deeper issue here, however, is that our country lacks systems of support for parents across the income spectrum to raise their children. The United States is the only developed country that does not guarantee some paid maternity leave. We are also unique among developed countries in that our public policies and systems for early childhood education are not built on an expectation of universal access to preschool for all children ages 3-5. And we spend a smaller percentage of GDP on supporting young children and their families than most developed countries.

To be clear, parents, not government, are responsible for raising young children. But public policies can support parents to fulfill their responsibilities by helping them balance family and work responsibilities, cultivating a stable and thriving child care market, and helping lower and moderate income families pay for the costs of child care and early education. Our current systems and policies by and large don't do that. And as a result, too many American families are largely on their own.

This has particularly negative effects for low-income children and their families, who lack the resources that enable affluent families to compensate for gaps in our current systems. But the status quo doesn't work that well for affluent families, either. Much has been written about elite professional parents' struggles to balance demands of work and family. And in many urban areas, highly educated professionals can't find the kinds of high-quality early-learning experiences they want for their children, even when they can afford to pay dearly for them. The same forces that price low-income families out of the market also undermine supply of the services that higher-income families want.

Yet that depressing reality may also provide a reason for hope: In his book and articles, Reeves highlights policies and systemic arrangements, in both public K-12 schooling and higher education, that entrench the educational advantage of affluent Americans, creating a perceived zero sum game where efforts to advance equity for disadvantaged youngsters garner opposition from affluent parents seeking to preserve their children's advantages. There is room for disagreement about Reeves' diagnosis.

In early childhood, however, where current systemic arrangements fail to meet the needs of both low-income families and more affluent parents, there's an opportunity to build common cause around strategies to support parents and strengthen the early childhood sector in ways that both enhance equity for disadvantaged children and help affluent parents to find and purchase the kinds of high-quality care they want.

Some critics have argued that increased public investment in early childhood programs, such as universal preschool, will increase, rather than mitigate educational inequities, because affluent parents will find ways to manipulate new programs to further advance their children's advantages. This is largely a policy design, question, however. Many other countries have been able to build systems that make preschool universally accessible and support all families, while also targeting increased support to the most at-risk children, thereby mitigating inequities. And these systems seem to work better in addressing inequality than the patchwork of means-tested early learning programs that exists in the United States today.

Inequitable access to educational opportunity is a serious problem in our country today – and one that starts far sooner than we often realize. If we're serious about extending opportunity and increasing social mobility for all children, we need to start sooner.

The School-to-Prison Pipeline
Teaching Tolerance
Spring 2013

In Meridian, Miss., police routinely arrest and transport youths to a juvenile detention center for minor classroom misbehaviors. In Jefferson Parish, La., according to a U.S. Department of Justice complaint, school officials have given armed police "unfettered authority to stop, frisk, detain, question, search and arrest schoolchildren on and off school grounds." In Birmingham, Ala., police officers are permanently stationed in nearly every high school.

In fact, hundreds of school districts across the country employ discipline policies that push students out of the classroom and into the criminal justice system at alarming rates—a phenomenon known as the school-to-prison pipeline.

Last month, Sen. Richard Durbin, D-Ill., held the first federal hearing on the school-to-prison pipeline—an important step toward ending policies that favor incarceration over education and disproportionately push minority students and students with disabilities out of schools and into jails.

In opening the hearing, Durbin told the subcommittee of the Senate Judiciary Committee, "For many young people, our schools are increasingly a gateway to the criminal justice system. This phenomenon is a consequence of a culture of zero tolerance that is widespread in our schools and is depriving many children of their fundamental right to an education."

A wide array of organizations—including the Southern Poverty Law Center, the NAACP and Dignity in Schools—offered testimony during the hearing. They joined representatives from the Departments of Education and Justice to shine a national spotlight on a situation viewed far too often as a local responsibility.

"We have a national problem that deserves federal action," Matthew Cregor, an attorney with the NAACP Legal Defense Fund, explained. "With suspension a top predictor of dropout, we must confront this practice if we are ever to end the 'dropout crisis' or the so-called achievement gap." In the words of Vermont's Sen. Patrick Leahy, "As a nation, we can do better."

What is the School-to-Prison Pipeline?
Policies that encourage police presence at schools, harsh tactics including physical restraint, and automatic punishments that result in suspensions and out-of-class time are huge contributors to the pipeline, but the problem is more complex than that.

The school-to-prison pipeline starts (or is best avoided) in the classroom. When combined with zero-tolerance policies, a teacher's decision to refer students for punishment can mean they are pushed out of the classroom—and much more likely to be introduced into the criminal justice system.

Who's in the Pipeline?

Students from two groups—racial minorities and children with disabilities—are disproportionately represented in the school-to-prison pipeline. African-American students, for instance, are 3.5 times more likely than their white classmates to be suspended or expelled, according to a nationwide study by the U.S. Department of Education Office for Civil Rights.

Black children constitute 18 percent of students, but they account for 46 percent of those suspended more than once.

For students with disabilities, the numbers are equally troubling. One report found that while 8.6 percent of public school children have been identified as having disabilities that affect their ability to learn, these students make up 32 percent of youth in juvenile detention centers.

The racial disparities are even starker for students with disabilities. About 1 in 4 black children with disabilities were suspended at least once, versus 1 in 11 white students, according to an analysis of the government report by Daniel J. Losen, director of the Center for Civil Rights Remedies of the Civil Rights Project at UCLA.

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A landmark study published last year tracked nearly 1 million Texas students for at least six years. The study controlled for more than 80 variables, such as socioeconomic class, to see how they affected the likelihood of school discipline. The study found that African Americans were disproportionately punished compared with otherwise similar white and Latino students. Children with emotional disabilities also were disproportionately suspended and expelled.

In other studies, Losen found racial differences in suspension rates have widened since the early 1970s and that suspension is being used more frequently as a disciplinary tool. But he said his recent study and other research show that removing children from school does not improve their behavior. Instead, it greatly increases the likelihood that they'll drop out and wind up behind bars.

Punishing Policies

The SPLC advocates for changes to end the school-to-prison pipeline and has filed lawsuits or civil rights complaints against districts with punitive discipline practices that are discriminatory in impact.

According to the U.S. Department of Justice, the number of school resource officers rose 38 percent between 1997 and 2007. Jerri Katzerman, SPLC deputy legal director, said this surge in police on campus has helped to criminalize many students and fill the pipeline.

One 2005 study found that children are far more likely to be arrested at school than they were a generation ago. The vast majority of these arrests are for nonviolent offenses. In most cases, the students are simply being disruptive. And a recent U.S. Department of Education study found that more than 70 percent of students arrested in school-related incidents or referred to law enforcement are black or Hispanic. Zero-tolerance policies, which set one-size-fits-all punishments for a variety of behaviors, have fed these trends.

Best Practices

Instead of pushing children out, Katzerman said, “Teachers need a lot more support and training for effective discipline, and schools need to use best practices for behavior modification to keep these kids in school where they belong.”

Keeping at-risk kids in class can be a tough order for educators under pressure to meet accountability measures, but classroom teachers are in a unique position to divert students from the school-to-prison pipeline.

Teachers know their students better than any resource officer or administrator—which puts them in a singularly empowered position to keep students in the classroom. It’s not easy, but when teachers take a more responsive and less punitive approach in the classroom, students are more likely to complete their education.

The information in "A Teacher's Guide to Rerouting the Pipeline" highlights common scenarios that push young people into the school-to-prison pipeline and offers practical advice for how teachers can dismantle the school-to-prison pipeline.

Avoiding the Pipeline

How can school districts divert the school-to-prison pipeline?

1. Increase the use of positive behavior interventions and supports.
2. Compile annual reports on the total number of disciplinary actions that push students out of the classroom based on gender, race and ability.
3. Create agreements with police departments and court systems to limit arrests at school and the use of restraints, such as mace and handcuffs.
4. Provide simple explanations of infractions and prescribed responses in the student code of conduct to ensure fairness.
5. Create appropriate limits on the use of law enforcement in public schools.
6. Train teachers on the use of positive behavior supports for at-risk students.